Washington State Department of Health

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Interim Recommendations to Mitigate Health Care Worker Staffing Shortage During the COVID-19 Pandemic

In times of COVID-19 surge, health care facilities may experience health care personnel (HCP) shortages due to employee illness, exclusion from work due to higher-risk exposure, the need to care for ill family members, fear of illness, and burnout. Maintaining appropriate staffing in health care facilities is essential to providing a safe work environment for HCP and safe patient care. This guidance is for COVID-19 contingency capacity staffing and crisis capacity staffing, which are defined as:

Contingency Capacity Staffing: When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem.

Crisis Capacity Staffing: When staffing shortages occur, healthcare facilities and employers, in collaboration with human resources and occupational health services, may need to implement crisis capacity staffing strategies to continue to provide patient care when there threatens to be insufficient staff to provide safe patient care.

These strategies are independent of "contingency standards of care" and "crisis standards of care" based on the framework developed by the National Academies of Medicine. Unlike implementation of crisis standards of care, which in Washington requires a formal statewide declaration, healthcare facilities and employers may choose to implement contingency capacity staffing and crisis capacity staffing independently.

Strategies to Mitigate Health Care Personnel Staffing Shortages

During HCP staffing shortages facilities should follow guidance from the Centers for Disease Control and Prevention (CDC):

- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- Strategies to Mitigate Healthcare Personnel Staffing Shortages

CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages offer a continuum of options for addressing staffing shortages. Contingency and then crisis capacity staffing strategies augment conventional strategies and should be considered and implemented sequentially. If experiencing staff shortage, facilities should reach out to their local health jurisdiction and local emergency management as well as their regional health care coalition.

Health care facilities should understand that shortening the duration of work restriction might result in additional transmission risks to health care personnel and patients. Health care facilities, in collaboration with risk management, should inform patients and HCP when the facility is operating under contingency capacity staffing or crisis capacity staffing standards, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill critical staffing needs.

Health care facilities may consider allowing **willing** HCP who are infected with SARS-CoV-2 and are not moderately to severely immunocompromised to return to work earlier than conventional timeframes if implementing contingency or crisis staffing mitigation measures. Prior to agreeing to return to work, willing HCP should assess personal symptoms, current health status, and determine their personal readiness to safely return to work**.** Mitigation measures should be implemented sequentially (i.e., implementing contingency before crisis).

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem including adjusting staff schedules, hiring additional HCP, rotating HCP to positions that support patient care activities:

- Cancel all non-essential procedures and visits
- Attempt to address social factors that might prevent HCP from reporting to work Identify additional HCP to work in the facility
- As appropriate, ask HCP to postpone elective time off with consideration for the mental health benefits of time off

Preventing illness among HCP is a key component of mitigating staffing shortages. With the SARS-CoV-2 omicron variant, there is increasing evidence that booster doses are necessary to provide the best protection against infection and severe disease. We strongly encourage all health care personnel to get a booster dose of vaccine and for health care employers to make access to booster doses of vaccine available onsite for their employees. Health care personnel should also get a yearly influenza vaccination.

Summary of CDC's recommendations for HCP exclusion from work according to staffing mitigation strategy

Work Exclusion for HCP	Vaccination Status	Mitigation Strategy		
		Conventional Capacity Staffing	**Contingency Capacity Staffing**	**Crisis Capacity Staffing**
Tested positive with SARS-CoV-2 Infection	• Up to date and not up to date	If asymptomatic or mildly symptomatic with improving symptoms and fever free for 24 hrs. without fever-reducing medications, exclude from work for: • 10 days **OR** • 7 days with negative test** within 48 hours before returning to work	If asymptomatic or mildly symptomatic with improving symptoms and fever free for 24 hrs. without fever-reducing medications exclude from work* for at least 5 days since symptoms first appeared (day 0) with or without negative test**	No work restriction with prioritization considerations (e.g., asymptomatic should be prioritized for early return to work)*
Asymptomatic with high risk exposure	• Up to date	No work restriction with negative test** on post exposures day 2 and 5-7	No work restrictions	No work restrictions
	• Not up to date	Exclude from work for: • 10 days **OR** • 7 days with negative test** on post exposure day 2 and 5-7	No work restriction with negative tests** on post exposure days 1, 2, 3, & 5-7; If testing supplies are limited, testing should be prioritized for 1-2 days after the exposure and, if negative, 5-7 days after exposure	No work restrictions. Test** if possible.

*Health care facilities may consider allowing **willing** HCP who are infected with SARS-CoV-2 and are not immunocompromised to return to work earlier than conventional timeframes if implementing contingency or crisis staffing mitigation measures. Prior to agreeing to return to work, willing HCP should assess personal symptoms, current health status, and determine their personal readiness to safely return to work**.** Mitigation measures should be implemented sequentially (i.e., implementing contingency before crisis)

** Either an antigen test or NAAT can be used when referenced in the criteria above. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

Considerations for Shortened Exclusion from Work for Health Care Personnel After a High-Risk Exposure to SARS-CoV-2

If all other conventional and contingency capacity staffing strategies have failed, facilities may consider allowing asymptomatic HCP with high-risk exposures who have not received all recommended doses COVID-19 vaccine, including a booster, to return to work before the end of their indicated exclusion from work. HCP who have received all recommended COVID-19 vaccine doses and a booster would not generally be excluded from work and have no work restrictions. All HCP with higher-risk exposures, regardless of exclusion from work and regardless of vaccination status, should have at minimum post-exposure testing immediately (on post-exposure day 1 or 2) and on day 5-7 post-exposure. See CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic and DOH's Testing in Long-Term Care Facilities.

If allowed to return before the end of their indicated exclusion from work, any HCP who is either not up to date with all recommended COVID-19 vaccine doses should:

- Continue to be screened for symptoms before each shift and should either not report to work, or stop working and notify their supervisor or occupational health services prior to leaving work if they develop even mild symptoms. These HCP should be prioritized for SARS-CoV-2 testing.
- Have expanded post-exposure testing when testing supplies allow on each of the first three post-exposure days and on post-exposure day 5-7 (i.e., days 1,2,3, and 5-7), and be tested immediately if symptoms develop.
- Consider use of a respirator or, if not available, a well-fitting facemask at all times in the facility.
- If they test positive for SARS-CoV-2, immediately be excluded from work until they meet all return-to-work criteria and according to the staffing stortage mitigation strategy in place. The facility should begin identifying and notifying patients, staff, and visitors who may have been exposed. The HCP should wear a respirator or, if not available, a well-fitting facemask at all times in the facility.

Considerations for Shortened Exclusion from Work for Health Care Personnel with SARS-CoV-2 Infection

Facilities may consider allowing asymptomatic or mildly symptomatic HCP who are willing to return to work before the end of their indicated isolation period in contingency staffing shortage mitigation strategies if:

- At least 5 days have passed since symptoms first appeared (day 0), **and**
- At least 24 hours have passed since last fever without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.

If allowed to return before the end of their isolation period in contingency or crisis staffing shortage mitigation strategies, the HCP should:

- Be prioritized for assignment to care for patients with suspected or confirmed COVID-19, preferably in a cohort setting such as a COVID-19 Unit.
- Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
- Wear a respirator or, if not available, a well-fitting facemask at all times while in the facility, even when they are in non-patient care areas such as breakrooms.
- To the extent possible, they should practice physical distancing from others.
- Separate themselves from others if they must remove their respirator or well-fitting facemask, for example, in order to eat or drink.

Facilities should consider providing NIOSH approved respirators for other HCPs working in the same physical areas as any HCP returning to work before the end of their indicated isolation period.

Definitions

COVID-19 Unit: Several rooms or a dedicated area for cohorting a number of COVID-19 positive patients.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Health care personnel: All paid and unpaid persons serving in health care settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home health care personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the facility, and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, dental personnel, and volunteer personnel).

Immunocompromised: moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC

- Other factors, such as end-stage renal disease, may pose a lower degree of immunocompromise and not clearly affect decisions about need for or duration of Transmission-Based Precautions if the individual had close contact with someone

with SARS-CoV-2 infection. However, people up to date with SARS-CoV-2 vaccination in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, even when not otherwise recommended for up to date individuals.

- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Patient: Anyone receiving care for medical reasons or assistance with activities of daily living, including clients and residents.

Respirator: A personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators, including those intended for use in health care, are certified by the CDC/NIOSH.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

SARS-CoV-2 test: Antigen test or nucleic acid amplification test (NAAT). Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

Up to date with all recommended COVID-19 vaccine dose: Per CDC's Stay Up to Date with Your Vaccines

More COVID-19 Information and Resources

Stay up to date on the current COVID-19 situation in Washington, Governor Inslee's proclamations, symptoms, how it spreads, and how and when people should get tested. See our Frequently Asked Questions for more information.

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data show that communities of color are disproportionately impacted by COVID-19. This is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. Stigma will not help to fight the illness. Share only accurate information to keep rumors and misinformation from spreading.

- WA State Department of Health 2019 Novel Coronavirus Outbreak (COVID-19)
- WA State Coronavirus Response (COVID-19)
- Find Your Local Health Department or District
- CDC Coronavirus (COVID-19)
- Stigma Reduction Resources
- COVID Vaccine Locator

Have more questions or need help scheduling a vaccine appointment? Call our COVID-19 Information hotline: **1-800-525-0127**

Monday – 6 a.m. to 10 p.m., Tuesday – Sunday and observed state holidays, 6 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language.** For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.